

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
INCRELEX(mecasermin)

Patient name: _____ Medicaid or SS# _____
Physician Name: _____ Contact person: _____
Phone#: _____ Ext. and options _____ Fax# _____
Pharmacy _____ Pharmacy Phone#: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO (801) 536-0477**

CRITERIA:

- ▶ Patient age >2 and <18. Must start therapy before age 16
- ▶ Diagnosis of growth failure
- ▶ Documented diagnosis of Primary IGF-1 Deficiency
- ▶ Normal to low GH level and IGF-1 level at or below -3.0 standard deviations from normal levels
- ▶ Must have a height stature less than the 5th percentile on the PHYSICAL GROWTH NCHS PERCENTILES CHART for correct age and sex.
- ▶ Patient does not have cancer
- ▶ Patient is not on chronic steroid therapy
- ▶ Patient does not have uncorrected thyroid deficiencies

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Same criteria as required for initial authorization

